SECTION 4: OVERVIEW OF HEALTH INSURANCE REGULATION

The Division of Insurance, within the Colorado Department of Regulatory Agencies (DORA), is the state's primary regulator of all types of insurance companies, including health insurance carriers operating in the state. This section provides an overview of the Division's regulatory authority as well as information about the Division's progress towards DORA's primary mission, consumer protection.

State-Regulated Commercial Health Insurance

Insurance regulation is structured around several key functions, including company licensing, producer licensing, product regulation, market conduct, financial regulation and consumer services.

The Division of Insurance serves the public interest through the following areas of responsibilities:

- Provide a prompt, effective, complaint resolution process for Colorado consumers.
- Provide prompt and effective service and education to Colorado consumers, the public and regulated entities.
- Promote and preserve a sound, competitive insurance marketplace through effective state regulation.
- Promote access to affordable insurance that allows for adequate consumer choice.
- Promote and develop more streamlined, uniform and efficient regulatory processes.
- Ensure that management systems are in place to operate the Division efficiently and effectively.

The Division's role regulating the different insurance market segments varies widely, but there are four major responsibilities that are universal: consumer protection, financial solvency, market regulation and rate regulation.

Consumer Protection

The responsibility of consumer protection is accomplished through addressing consumer complaints, verifying the financial ability of the health insurer to pay claims through financial examinations, checking that an insurer's marketing practices are honest and approving only premium rate changes that are not excessive, inadequate or unfairly discriminatory.

Health insurers are subject to a wide range of consumer protections. Through statutes and regulations, the Division assures that health insurers are providing health insurance in a fair, non-discriminatory way, and according to the law of the State of Colorado.

In determining if the rate is excessive or inadequate, the Commissioner may consider profits, dividends, annual financial statements, subrogation funds credited, investment income or losses, unearned premium reserve, reserve for losses, surpluses, executive salaries, expected benefits ratios, and any other appropriate actuarial factors as determined by accepted actuarial standards of practice.

Financial Solvency

Financial Regulation insures carriers can pay claims. The state enforces financial solvency and consumer protection requirements for all health insurers. Financial regulation provides crucial safeguards for consumers. Financial regulation is maintained by states at the National Association of Insurance Commissioners (NAIC), the world's largest insurance financial database, which provides a 15-year history of annual and quarterly filings forover5,000 insurance companies.

Periodic financial examinations occur on a scheduled basis. State financial examiners investigate a company's accounting methods, procedures and financial statement presentation. These exams verify and validate what is presented in the company's annual statement to ascertain whether the carrier is in good financial standing.

When an examination of financial records shows a company to be financially impaired, the state insurance department takes control of the company. Aggressively working with financially troubled companies is a critical part of the regulator's role. In the event the company must be liquidated or becomes insolvent, the states maintain a system of financial guaranty funds that cover consumers' personal losses.

Market Regulation

Market regulation attempts to ensure fair and reasonable insurance prices, products and trade practices in order to protect consumers. With improved cooperation among states and uniform market conduct examinations, regulators hope to ensure continued consumer protections at the state level.

Market conduct examinations occur on a routine basis, but also can be triggered by complaints against an insurer. These exams review agent-licensing issues, complaints, types of products sold by the company and agents, agent sales practices, proper rating, claims handling and other market-related aspects of an insurer's operation.

When violations are found, the Division of Insurance makes recommendations to improve the company's operations and to bring the company into compliance with state law. In addition, a company may be subject to civil penalties and/or certificate suspension or revocation.

Rate Regulation

Rates are reviewed by the Colorado Division of Insurance to determine if rates are "excessive, inadequate or unfairly discriminatory. "Excessive Rates" occur when unreasonable high profits result or expenses are high in relation to the benefits provided. "Inadequate Rates" are where rates are not sufficient to pay losses and expenses, or where the use of the rates will result in a monopoly. "Unfairly Discriminatory" rates occur when the product prices do not equitably reflect differences in risks.

The Division reviews several thousand filings a year to determine if the rates are justified and comply with Colorado laws and regulations. Below are the resulting consumer savings due to the Division's review of health insurance filings and intervention for the past five years.

Colorado Division of Insurance - Rates and Forms Consumer Savings From Review and Intervention 2006-2010	
2006	**$3,155,712**
2007	**$3,725,174**
2008	**$11,833,682**
2009	**$32,094,080**
2010	**$32,295,133**

Table 26: Colorado Consumer Savings Realized through Reviews and Intervention

Rate standards are included in state laws and are the foundation for the acceptance, denial or adjustment to rate filings. Typical rate standards included in state laws require that benefits are reasonable in relation to the premium charged. This is usually accomplished by reference to an expected loss ratio which is the ratio of the expected incurred claims to the expected earned premiums. The loss ratio standards are either specified in law or set by the regulatory authorities. For example, the minimum loss ratio for Medicare Supplement insurance is 65% for individual business and 75% for group business. The expected loss ratio is calculated by projecting earned premiums and incurred claims, and determining the lifetime loss ratio.

The following are the two types of health rate procedures in Colorado:

Prior Approval: is a filing procedure that requires a rate change to be affirmatively approved by the Commissioner prior to distribution, release to agents, collections of premium, advertising or any other use of the rate. Under no circumstances shall the carrier provide insurance coverage under the rates until after the proposed effective date specified in the rate filing. Carriers may bill members but not require the

member to remit premium, prior to the effective date of the rate change.

In 2008, Colorado passed HB 08-1389, which requires the carrier to submit to the Colorado Division of Insurance for prior approval its expected health rate increases at least 60 days prior to the proposed implementation of the rates.

The Division reviews the proposed rate change and supporting documentation to determine whether the company has provided all the information required by law and whether or not the requested rate is justified. If a requested rate increase is not justified, HB08-1389 gives the Division the authority to disapprove the rate or to request additional supporting documentation from the carrier. Also, if a filing requesting a rate increase is incomplete (i.e., carrier did not provide all the required justification), the filing may be disapproved. However, if the rate increase is justified and meets all applicable laws and regulations, the Division will approve the filing.

File and Use: is a filing procedure that requires rates and rating data to be filed with the Division of Insurance concurrent with or prior to distribution, release to producers, and collection of premium, advertising or any other use of the rates. Under no circumstance shall the carrier provide insurance coverage under the rates until after the proposed effective date. Carriers may bill members, but not require the member remit the premium prior to the effective date of the rate change.

Submissions of Rate Filings in Colorado

All companies must submit rate filings whenever the rates charged to new or renewing policyholders or certificate-holders differ from the rates on file with the Division of Insurance. Included in this requirement are changes due to periodic recalculation of experience, change in rate calculation methodology or change(s) in the trend or other rating assumptions.

All companies must submit a rate filing on at least an annual basis, when rating factors are used which automatically change rates on a predetermined basis, such as trend, durational factors, or the Index Rate for small group business, for continued appropriateness. These rate filings must contain detailed support as to why the assumptions continue to be appropriate. All companies must submit a rate filing when the rates are changed on an existing product, even if the rate change only pertains to new business.

This chart summarizes the differences in regulatory requirements in Colorado for the individual, small group and large group markets.

Summary of Rating Factors for Private Health Plans in Colorado			
Rating Factor	**Individual Plans**	**Small Group Plans**	**Large Group Plans**
Attained Age: Age Bands (5-year)	Applies	Applies	May Apply: Carriers use age in developing rates but supply an ageless rate to employers.
Age (no bands)	Applies	Does Not Apply	Does Not Apply
Family Composition: 4 Tiers	Applies	Applies	As specified by the group.
Gender	Unisex Rating	Unisex Rating	Applies
Area Factors:	Usually based on zip code, grouped by county.	Based on county where small group is located and as required by Colorado Insurance Regulation 4-6-7	Limited to the area factors filed for use by the carrier.

Summary of Rating Factors for Private Health Plans in Colorado			
Rating Factor	**Individual Plans**	**Small Group Plans**	**Large Group Plans**
Smoking Status or Tobacco Use:	Rate-up or discount	Rate-up or discount up to 15% for tobacco use; or 10% discount for smoking cessation. Must be applied at the individual level and cannot be aggregated over the entire group.	No prohibition or requirement specified in CO law.
Health Status:	Tiers by each individual covered. (Preferred, Standard, Non-Standard) - Can be medically underwritten.	Not allowed after 12/31/2008.	Aggregated for group and limited to the range or formula filed for use by the carrier.
Claims Experience:	Not allowed as a separate factor for rate calculation for an individual policyholder.	Not allowed after 12/31/2008.	Aggregated for group and limited to the range or formula filed for use by the carrier.
Standard Industrial Classification:	Does Not Apply	Can be used to adjust rate within range filed by carrier and limited by increase of 15% and between 0. 75 and 1. 10% of index rate. In statute: § 10-16-05(8. 5)(a)(V), C. R. S.	Aggregated for group and limited to the range filed for use by the carrier.
Plan Design Factors: • **Deductibles, etc.** • **Managed Care** • **Networks**	Applies	Applies	Applies

Table 27: Summary of Rating Factors for Private Health Plans in Colorado

Appendix: Colorado Health Premiums, Incurred Losses and Medical Loss Ratios

2010 Colorado Health Benefit Plan Coverage Summary by Company Type			
Colorado 2010	**Direct Earned Premium**	**Direct Losses Incurred**	**Pure Direct Loss Ratio**
	Health Companies		
Individual Coverage	$321,646,795	$266,758,120	82.94%
Small Group Coverage	$720,642,282	$599,206,410	83.15%
Large Group Coverage	$2,477,300,292	$2,177,959,724	87.92%
Government Coverage	$1,675,914,627	$1,423,155,835	84.92%
Other Excluded Business	$36,219,667	$26,339,009	72.72%
Other Health Coverage	$42,006,951	$38,240,217	91.03%
Health Company Totals	**$5,273,730,614**	**$4,531,659,315**	**85.93%**
Property Companies			
Individual Coverage	$7,914,379	$5,900,273	74.55%
Small Group Coverage	$0	-$10,179	N/A
Large Group Coverage	$808,898	$795,013	98.28%
Government Coverage	$0	$0	N/A
Other Excluded Business	$7,480,472	$5,258,642	70.30%
Other Health Coverage	$9,729,090	$17,632,596	181.24%
Property Company Totals	**$25,932,839**	**$29,576,345**	**114.05%**
Life Companies			
Individual Coverage	$338,989,931	$231,158,046	68.19%
Small Group Coverage	$504,817,634	$389,337,219	77.12%
Large Group Coverage	$566,514,893	$450,707,797	79.56%
Government Coverage	$406,673,564	$316,091,575	77.73%
Other Excluded Business	$243,069,116	$182,744,437	75.18%
Other Health Coverage	$226,232,061	$180,678,690	79.86%
Life Company Totals	**$2,286,297,200**	**$1,750,717,766**	**76.57%**
Fraternal Companies			
Individual Coverage	$330,377	$86,851	26.29%
Small Group Coverage	$0	$0	N/A
Large Group Coverage	$0	$0	N/A
Government Coverage	$0	$0	N/A
Other Excluded Business	$0	$0	N/A
Other Health Coverage	$86,851	$50,211	57.81%
Fraternal Company Totals	**$417,228**	**$137,062**	**32.85%**
All Health Benefit Plans			
Colorado Totals	**$7,586,377,881**	**$6,312,090,487**	**83.20%**

Table 28: 2010 Colorado Health Coverage Summary by Company Type

2010 Total Colorado Health Coverage Summary by Company Type				
Health Companies	**Written Premium**	**Earned Premium**	**Incurred Losses**	**Pure Direct Loss Ratio**
Health Companies				
Individual Comprehensive	$393,382,165	$392,789,790	$325,974,426	82.99%
Group Comprehensive	$2,660,040,599	$2,660,136,034	$2,352,870,824	88.45%
Medicare Supplement	$31,392,095	$31,254,621	$21,559,874	68.98%
Vision Only	$41,857,276	$41,858,731	$31,647,374	75.61%
Dental Only	$944,071,020	$822,901,099	$779,491,027	94.72%
Federal Employees Health Benefit Plan	$564,771,627	$560,861,538	$525,628,413	93.72%
Title XVIII Medicare	$1,662,938,570	$1,662,468,067	$1,419,582,641	85.39%
Title XIX Medicaid	$43,347,697	$43,348,524	$36,232,911	83.59%
Other	$73,615,924	$75,596,074	$70,166,612	92.82%
Health Companies Total	$6,415,416,973	$6,291,214,478	$5,563,154,102	88.43%
Property Companies				
Group accident and health	$38,312,770	$35,807,889	$25,957,292	72.49%
Credit A&H (group and individual)	$1,520,504	$1,508,595	$337,463	22.37%
Collectively renewable A&H	$656	$593	$5,145	867.62%
Non-cancelable A&H	$268	$18,444	$2	0.01%
Guaranteed renewable A&H	$23,366,626	$12,146,008	$16,963,992	139.67%
Non-renewable for stated reasons only	$2,103,684	$2,217,898	$1,041,352	46.95%
Other accident only	$362,439	$395,164	$62,259	15.76%
Medicare Title XVIII exempt from state taxes or fees	$0	$0	$0	N/A
All other A&H	$1,407,573	$1,419,032	$2,797,354	197.13%
Federal employees health benefits program premium	$0	$0	$0	N/A
Property Companies Total	$67,074,520	$53,513,623	$47,164,859	88.14%
Life Companies				
Group Policies	$2,015,286,496	$2,009,769,080	$1,550,385,324	77.14%
Federal employees health benefits program premium	$19,609,191	$19,408,910	$17,111,678	88.16%
Credit (group and individual)	$4,898,624	$7,010,167	$2,725,042	38.87%
Collectively renewable policies	$401,564	$400,835	$217,526	54.27%
Medicare Title XVIII exempt from state taxes or fees	$480,753,682	$478,471,788	$388,120,729	81.12%
Non-cancelable (other individual certificates)	$80,946,194	$80,943,620	$84,047,562	103.83%
Guaranteed renewable (other individual certificates)	$381,634,091	$380,483,708	$219,670,278	57.73%
Non-renewable for stated reasons only (other individual certificates)	$232,485,184	$231,233,840	$140,134,950	60.60%
Other accident only (other individual certificates)	$894,676	$909,489	$470,699	51.75%
All other (other individual policies)	$29,678,040	$28,535,674	$16,487,157	57.78%
Totals (other individual certificates)	$725,638,190	$722,106,334	$460,810,643	63.81%
Totals (collectively renewable and other individual policies)	$3,246,587,741	$3,237,167,116	$2,419,370,952	74.74%
Life Companies total	$7,218,813,673	$7,196,440,561	$5,299,552,540	73.64%
Fraternal Companies				
Collectively renewable certificates	$10	$0	$0	N/A
Non-cancelable (other individual certificates)	$1,023,113	$1,012,419	$635,691	62.79%
Guaranteed renewable (other individual certificates)	$11,281,368	$11,255,933	$11,233,966	99.80%
Non-renewable for stated reasons only (other individual certificates)	$44,067	$44,318	$57,884	130.61%
Other accident only (other individual certificates)	$13,586	$13,885	$12,121	87.30%
Medicare Title XVIII exempt from state taxes or fees	$0	$0	$0	N/A
All other (other individual certificates)	$49,091	$48,163	$62,042	128.82%
Fraternal Companies Total	$12,411,235	$12,374,718	$12,001,704	96.99%
All Health Coverage Plans				
Colorado Totals	**$13,713,716,401**	**$13,553,543,380**	**$10,921,873,205**	**80.58%**

Table 29: 2010 Total Colorado Health CoverageSummary by Company Type

Glossary of Terms

Accident and Health Insurance-A type of coverage that pays benefits, sometimes including reimbursement for loss of income, in case of sickness, accidental injury or accidental death.

Administrative Expenses-Expenses an insurer incurs to run its business. This includes all expenses that are not directly attributed to settling and paying claims of members. Examples are commissions, marketing and advertising expenses, and salaries of non-claims personnel.

ASO (Administrative Services Only) -An arrangement in which an employer hires a third party to deliver administrative services to the employer such as claims processing and billing; however, the employer bears the risk for claims. This is common in self-insured health care plans.

Anti-Selection or Adverse Selection-The tendency of individuals who believe they have a greater than average likelihood of loss to seek insurance protection to a greater extent than do those who believe they have an average or less than average likelihood of loss.

For example, those with severe health problems want to buy health insurance, and people going to a dangerous place such as a war zone want to buy more life insurance. Companies employing workers in dangerous occupations want to buy more workers' compensation coverage. In order to combat the problem of adverse selection, insurance companies try to reduce their exposure to large claims by either raising premiums or limiting the availability of coverage to such applicants.

Benefits-The amount of money paid under health insurance plans to cover the costs of healthcare. "Benefits" is a term also used to describe the services that could be covered in a health policy, such as doctor services, hospital services, laboratory tests, preventive care, prescription medicine and emergency care. Different policies may offer different benefit coverage, all of which will be specified in the policy.

Benefits Ratio-The ratio of the value of the actual benefits provided, not including dividends, to the value of the actual premiums, not reduced by dividends, over the entire period for which rates are computed to provide coverage. "Benefits ratio" is also known as "loss ratio."

Claim-A formal request for payment related to an event or situation that is covered under an in-force insurance policy.

Claim Adjustment Expenses-The cost of settling, recording and paying claims.

Coinsurance-A form of medical cost sharing in a health insurance plan that requires an insured person to pay a stated percentage of medical expenses after the deductible amount, if any, was paid.

Collectively Renewable-An insurer may not cancel an individual policy under any circumstances. However, the insurer may cancel all policies in similar rating classes.

Copayment-A form of medical cost sharing in a health insurance plan that requires an insured person to pay a fixed-dollar amount when a medical service is received. The insurer is responsible for paying the balance of the charge to the medical service provider.

Cost Containment Expense-Expenses that an insurer incurs to reduce the number of health services provided or the cost of services. This includes expenditures for disease or case management programs or patient education and other cost containment or quality improvement expenses.

Credit Insurance-Insurance on a debtor to provide indemnity for payments or loan balance, or any combination thereof, becoming due on a specific loan or other credit transaction upon contingency for which the insurance is obtained.

Deductible Leveraging-A component of premium increase for plans with a fixed deductible. If the price of services increases from one year to the next, but the deductible stays the same, then an economic adjustment is made to the premium to reflect the increase in the amount of benefits paid in comparison to

increases in the total cost of services. The effect of deductible leveraging occurs when one piece of the claim cost is “frozen” while others are not. An example of this is the co-pay.

For example; you incur an office visit that costs $80. In year one, the office visit co-pay paid by you, the policyholder, is $10 and the plan pays $70. In the second year there are no plan changes and you have another office visit. With 14% medical care trend that office visit in the second year will now cost $91.20 (1.14 X $80). You still pay $10, but now the plan pays $81.20. In this case, medical care inflation to you, the policyholder, is zero (0%) while medical care inflation to the plan is not 14% but 16% ($81.20 divided by $70). This effect of deductible leveraging can also occur with fixed deductibles. Fixed deductibles will result in greater inflation in the premium you pay than the underlying trend in medical care costs. The larger the deductible, the greater the impact on premium inflation.

Dividends-The distribution of earnings to the carrier’s owners during the year. If an insurer is publicly held, then the dividends would be returned to stockholders. If the insurer is a mutual company, the dividends are returned to the policyholders, who are considered the owners of the company.

Direct Written Premium-The total premiums generated from all policies written by an insurance company within a given period of time.

Division-The Colorado Division of Insurance.

Domestic-Designates those companies incorporated or formed in this state.

Earned Premiums-The portion of the total premium amount corresponding to the coverage provided during a given period of time.

Experience Rating-A method of calculating group insurance premium rates by which the insurer considers the particular group’s prior claims and expense experience.

Fully insured plan-A plan where the employer contracts with another organization to assume financial responsibility for the enrollees’ medical claims and for all incurred administrative costs.

Incurred Claims -The total amount of claims occurring during a given time period.

Guaranteed Renewable-An insurer may not cancel the policy under any circumstances, but subject to certain conditions (regulatory approval, adverse experience), the premium rates may be increased. It is the most common contract form, especially for individual medical and Long-Term Care insurance.

HMO (Health Maintenance Organization) -Prepaid health insurance plan that entitles members to services of participating physicians, hospitals and clinics. Members of the HMO pay a flat periodic fee for medical services.

Loss Adjustment Expense-The cost involved in an insurance company’s adjustment of losses under a policy.

Loss Ratio-The relationship of incurred losses plus loss adjustment expense to earned premiums.

Medicare-A federal health insurance program for people 65 years of age and older, and for people of all ages with certain disabilities. Eligibility is not income based.

Medicaid-A federal/state program that provides health coverage for certain categories of people with low incomes.

Medical loss ratio-The percent of health insurance premiums spent on medical claims. A 0.96 loss ratio means that 96 percent of the insurer’s health insurance premiums purchased medical services. The more technical definition of medical loss is claims incurred divided by net premium earned.

Member Months-A member month is defined as one member being enrolled for one month. For example, an individual who is a member of a plan for a full year generates 12 member months and a

family of five enrolled for six months generates (5 X 6) 30 member months. To obtain an approximate number of enrollees in a health plan, divide the member month figure by twelve.

NAIC-The National Association of Insurance Commissioners.

Net Claims Incurred-Cost for hospital and medical benefits, emergency room, and prescription drugs, minus recoveries from the reinsurer plus the change in the unpaid claim liability. The unpaid claim liability is the insurer's estimate of the cost for claims already reported but not yet paid and an estimate of claims incurred by a member but not yet submitted for payment.

Net Income-The net result of all revenue, claims incurred, expenses, investment results, taxes and write-offs. This report uses the term profit margin as synonymous with net income.

Net investment income (or gain)-Includes all income earned from invested assets minus expenses associated with investments plus the profit (or loss) realized from the sale of assets.

Net Income After Taxes-All expenses and losses over the year subtracted from all revenues and gains over the year. This calculation includes investment income, investment gains and other charges.

Net Premium Earned-The amount charged by the insurer to the policyholder for the effective period of the contract, reinsurance premiums, plus the change in the unearned premium liability. The unearned premium liability is the portion of the premium that has been received by the insurer for insurance that has not yet been provided. It is the amount that would have to be returned to the policyholder if the policy was canceled before the end of the policy period.

Non-cancelable-An insurer may not cancel the policy and may not increase premiums for any reason. Commonly used for Disability Income for most select risks.

Non-renewable for Stated Reasons Only-When the insured reaches a certain age or when all similar policies are not renewed, the policy is said to be nonrenewable for the reasons stated.

Premium-to-Surplus Ratio-This ratio measures an insurer's ability to support its existing business, as well as any growth. Since surplus provides a cushion for claims and expenses that exceed what the insurer expected, this ratio measures the adequacy of the surplus cushion available for unexpected claims and expenses.

Risk-Based Capital (RBC)-A method for evaluating an insurer's surplus in relation to its overall business operations in consideration of its size and lines of business written. An insurer's RBC is calculated by applying factors to various assets, premium and reserve items. The calculation produces the "authorized control level." The RBC ratio is the insurer's surplus divided by the authorized control level. The state is authorized to take regulatory action against an insurer that fails to maintain surplus equal to 200 percent of its authorized control level.

RBC Ratio-The measurement of the amount of capital (assets minus liabilities) an insurance company has as a basis of support for the degree of risk associated with its company operations and investments. This ratio identifies the companies that are inadequately capitalized by dividing the company's surplus by the minimum amount of capital that the regulatory authorities feel is necessary to support the insurance operations.

RBC Statistic-A ratio of authorized control level risked based capital of an insurance company to its total adjusted capital. This statistic determines regulatory action taken by the state's insurance commissioner

Reinsurance-A form of insurance that insurance companies buy for their own protection, "a sharing of insurance." An insurer (the reinsured) reduces its possible maximum loss on either an individual risk or a large number of risks by giving (ceding) a portion of liability to another insurance company (reinsurer).

Reinsurer-An insurance company that assumes all or part of an Insurance or Reinsurance policy written by a primary insurance company.

Reserves-Funds created to pay anticipated claims.

Reserves for Unpaid Claims-Expected payments for claims, including reported claims and estimates of potential claims.

Self-insured plan-A plan offered by employers who directly assume the major cost of health insurance for their employees. Some self-insured plans bear the entire risk. Other self-insured employers insure against large claims by purchasing stop-loss coverage. Some self-insured employers contract with insurance carriers or third party administrators for claims processing and other administrative services; other self-insured plans are self-administered. Minimum Premium Plans (MPP) are included in the self-insured health plan category. All types of plans (Conventional Indemnity, PPO, EPO, HMO, POS and PHOs) can be financed on a self-insured basis. Employers may offer both self-insured and fully insured plans to their employees. Self-insured plans are also called ERISA Plans.

Stop-loss coverage-A form of reinsurance for self-insured employers that limits the amount employers will have to pay for each person's health care (individual limit) or for the total expenses of the employer (group limit).

Surplus-The amount an insurance company's assets exceed its liabilities. Additional funds are surplus over and above what the insurer expects to pay out for medical claims, expenses, taxes and other obligations. All insurers must, by law, maintain minimum levels of surplus to ensure they will be able to meet their financial obligations to policyholders. Surplus includes common and preferred stock issued to its shareholders, any funds that are contributed to the insurer and the accumulation of the insurer's net income or losses since its inception.

Third Party Administrator (TPA)-An individual or firm hired by an employer to handle claims processing, pay providers and manage other functions related to the operation of health insurance. The TPA is not the policyholder or the insurer.

Total Adjusted Capital-Commonly refers to an insurance company's capital base under Standard & Poor's capital adequacy model. It includes shareholders' funds and adjustments on equity, asset values and reserves.

Total Net Underwriting Gain or Loss-The operating costs that are not allocated to hospital and medical payments, claim adjustment expenses or investment expenses.

Trend or Trending-Any procedure used to project claim costs from one period to another. Typically, "trend" is expressed as an annual percentage rate which represents the rate at which claim costs are expected to change over a period of one year.

Underwriting-The process of identifying and classifying the degree of risk represented by a proposed insured. An insurance company's process is to decide whether or not to issue coverage to an applicant and which benefits to offer at which premium rates. Its fundamental purpose is to make sure that the premiums collected reflect the company's estimate of future claim costs. An individual who has been subjected to this process is referred to as being "underwritten."

Underwriting Wear-off-The tendency for the differential in claim costs between groups of individuals who have been "underwritten" and groups of individuals who have not been "underwritten" to narrow over time. As a group of underwritten policies age, the effects of underwriting wear-off will result in higher premium rate increases for this group as compared to a similar group of policies that were not underwritten.